

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age
of deceased is shown on
Film No. G94 - May 15, 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-2

03775

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County.....

Calvert
W. Beach

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, Institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

M

5. Color or race

W

6. (a) Single, married, widowed, or divorced

W

8. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address

17. Removal to took effect (Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address

19. April 1, 1945 - Mar. 24, 1945
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State.....

Md

County.....

Calvert

City or town.....

126-6th & 42nd Sts.

(If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

4/1

1945 at 3:45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to

19...

and that I last saw him alive on

19...

Immediate cause of death.....

Head injury &
Broken neck

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

W. Beach Calvert

Md

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Public road

Means of Injury

Auto accident

Injured at work?

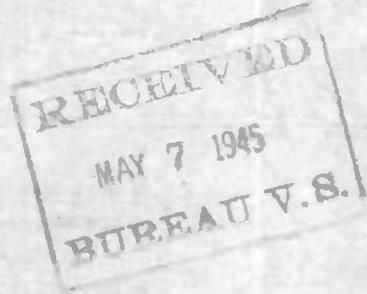
23. SIGNATURE

Hoyt W. Ross
M. D. and Surgeon
Dr. Hoyt W. Ross

M. D. or other

Address

Date signed 4/1/45



PLAINLY, WITH UNFALLING INK. Supply every item of information carefully. The correct age is especially important. **Physicians:** Please write the causes of death clearly and legibly.

PLEASE WRITE PLAINLY, WITH UNFADING INK.
is especially important. Physiology

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

03776

CERTIFICATE OF DEATH

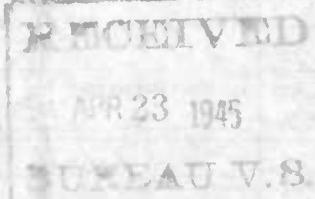
Reg. Diat. No.

1. PLACE OF DEATH: County..... Cabret City or town..... Solomons (If outside city or town limits, write RURAL and give nearest town)			2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State..... Md. County..... Cabret City or town..... Solomons (If outside city or town limits, write RURAL and give nearest town)		
How long in above place of death?..... Hospital, institution, or street address where death occurred:			Street No. (If rural, give LOCATION)		
How long in hospital or institution?.....			2.(a) If veteran, name war.....		
3. (a) FULL NAME <i>Rosa E. Gray</i>			3. (b) Social Security Number		
4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced		MEDICAL CERTIFICATION	
Female	White	Married		20. DATE OF DEATH..... April 14, 1945 at 5 a.m.	
6.(b) Name of husband or wife..... J. Walter Gray			21. I CERTIFY that death occurred on the date above stated; that I attended deceased from		
7. Birth date of deceased (mo., day, yr.)..... Nov. 24, 1873			19..... to..... 19.....		
8. AGE: Years Months Days If less than one day			and that I last saw h..... alive on.....		
71 4 20 hrs. min.			Immediate cause of death.....		
9. Birthplace..... Cabret County, Md. (Town, county, and state)			<i>Coronary Occlusion</i>		
10. Usual occupation..... Housewife			Due to..... <i>Hypertension, Cerebral Arterial Disease</i>		
11. Industry or business.....			Due to.....		
12. Name..... John Long			Other conditions.....		
13. Birthplace..... MD			(Include pregnancy within 3 months of death)		
14. Maiden name..... Mary Siebel			Major findings of operations.....		
15. Birthplace..... MD			Date of op.....		
16. Informant..... Dorothy Chambers			Autopsy results.....		
Address..... Rusty, Md.			PHYSICIAN: Please underline the cause to which death should be charged statistically.		
17. Burial..... Date thereof..... Apr. 16, 1945 (Burial, cremation, or removal. Which?)			22. VIOLENCE: If death was due to external causes, fill in the following:		
			Accident, suicide, or homicide..... Date of.....		
Cemetery or crematory..... Middlebush Chapel			Where did injury occur?..... (City or town)..... (County)..... (State).....		
Location..... Rusty, Md.			Injured at home, farm, Industry, public place (where?).....		
18. Funeral director..... A. B. Harkness & Son			Means of Injury..... Injured at work?		
Address..... Mutual, Md.					
19. Date rec'd by registrar..... Apr. 15, 1945			23. SIGNATURE..... <i>Dag Dett</i> M. D. or other..... Address..... Diane Redman Date signed..... Apr. 15, 1945		

23. SIGNATURE

M. D. or other

Address: June Maunz Date signed ...



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2

63777

CERTIFICATE OF DEATH

Reg. Dist. No. 52

1. PLACE OF DEATH:

County.....

City or town.....

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

B. (b) Name of husband or wife.....

7. Birth date of
deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Dec. 9, 1860

8. AGE:

Years

Months

Days

If less than one day

85

2

9

hrs.

min.

9. Birthplace.....

(Town, county, and state)

Sunderland Calvert Co. Md

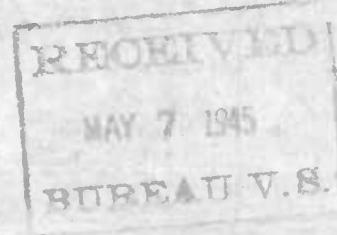
10. Usual occupation.....

Taxidermist

11. Industry or business

FATHER

MOTHER



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13

63782

CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH:

County *Cabell*City or town *Huntingtown, Md.*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Leroy Gibson Trutt

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male

White

Widowed

6. (b) Name of husband or wife

Henrietta Trutt

7. Birth date of deceased (mo., day, yr.)

July 5, 1868

6. (c) If alive, give age

years

8. AGE:

Years
76Months
9Days
8If less than one day
.hrs.
min.

9. Birthplace

Huntingtown, Md.

(Town, county, and state)

10. Usual occupation

Farmer

11. Industry or business

12. Name *Samuel Trutt*

13. Birthplace

Md.

14. Maiden name

Barbara Jane Gibson

15. Birthplace

Md.

16. Informant

Elmer Trutt

Address

Huntingtown, Md.

17. Burial

Date thereof *Apr 15 1945*

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Miranda

Location

Huntingtown, Md.

18. Funeral director

A. A. Tasker & Son

Address

Mutual, Md.

19. Date rec'd by registrar

19 45

J. N. Kise

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

Cabell

City or town

Huntingtown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

No

3. (b) Social Security Number

No

MEDICAL CERTIFICATION

20. DATE OF DEATH

April 13, 1945

al 10:45 A.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to.....

19.....

and that I last saw h.....alive on.....

19.....

Immediate cause of death

Cardiovascular Tuberculosis

DURATION

Due to.....

Due to.....

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide.....

Date of.....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

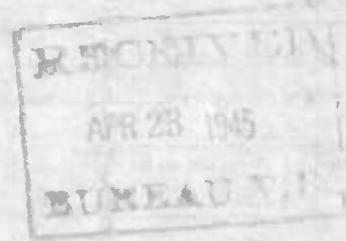
Dale Jeff

M. D. or other

Address

Sunbeam

Date signed



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *Mo*

13778

Reg. Dist. No. 51

CERTIFICATE OF DEATH

1. PLACE OF DEATH:

County *Calvert*
City or town *Prince Frederick Hospital*

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Henry Virgil Turner4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Single*6. (b) Name of husband or wife *--*7. Birth date of deceased (mo., day, yr.) *Aug. 17, 1926* 6. (c) If alive, give age *years*8. AGE: Years *18* Months *7* Days *15* It less than one day *hrs. min.*9. Birthplace *Calvert Co., Md.* (Town, county, and state)10. Usual occupation *Electricians Helper*

11. Industry or business

FATHER 12. Name *Raymond Turner*13. Birthplace *Calvert Co., Md.*MOTHER 14. Maiden name *Edna McKenney*15. Birthplace *Calvert Co., Md.*16. Informant *Edna Pfisterer*Address *405 E. Grindall St.*17. Burial Date thereof *4 - 3 - 45*
(Burial, cremation, or removal. Which?) *Accident* (month) (day) (year)Cemetery or crematory *Cedar Hill*Location *Baltimore, Md.*18. Funeral director *William Cook, Inc.*Address *Baltimore, Md.*19. *4-2 1945* *J. D. Clegg*
(Date rec'd by registrar) *Registrar*

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Md.* County *Baltimore*City or town *Baltimore* (If outside city or town limits, write RURAL and give nearest town)Street No. *405 Grindall St.*

(If rural, give LOCATION)

2.(a) If veteran, name war *WW*

3. (b) Social Security Number

MEDICAL CERTIFICATION

2D. DATE OF DEATH *April 2 1945* at *6:00 a.m.*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19. to 19.

end that I last saw h. alive on 19.

Immediate cause of death

Fracture of back neck

DURATION

24 hrs.

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide *Accident* Date of *4-1-45*Where did injury occur? *West Beach Calvert, Md.* (City or town) (County) (State)Injured at home, farm, industry, public place (where?) *State Road*Means of injury *Auto accident* Injured at work? *No*23. SIGNATURE *Hugh W Ward*M. D. or other *Deputy Medical Examiner*Address *Baltimore, Md.* Date signed *4-1-45*



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (70)

CERTIFICATE OF DEATH

03779

Reg. Dist. No. 51

1. PLACE OF DEATH:

County: Calvert

City or town: Prince Frederick

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr., 4 mos.

Hospital, Institution, or street address where death occurred:

Prince Frederick Hospital

How long in hospital or institution? About 2 hrs.

3. (a) FULL NAME

Charles Alphonsius Ward

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife: Lillian Ward, 661 Millbury St., Worcester, Mass.

6.(c) If alive, give age: Unkn.

years

7. Birth date of deceased (mo., day, yr.): 13 November 1918

8. AGE: Years: 26 Months: 5 Days: 3 If less than one day: hrs. min.

9. Birthplace: Scotland (Town, county, and state)

10. Usual occupation: Ship's Cook, U.S. Naval Reserve

11. Industry or business: U.S. Naval Service

12. Name: UNKNOWN

13. Birthplace:

14. Maiden name: Unknown Mary Gibbons

15. Birthplace:

16. Informant: C.C. L. R. C. Pharm. USN

Address: U.S. Naval Dispensary, Bellevue Annex, Navy Dept., Washington, D.C.

(Build, demolition, or removal. Which?)

Cemetery or crematory:

Location: Worcester, Mass.

18. Funeral director: Chambers

Address: 517 Eleventh St. S.E., Washington, D.C.

19. Date rec'd by registrar: 4-12-1945

Registrar: J. N. King

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md

County: Calvert

City or town: St. Michaels

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH: 4/16

1945 at 12:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

18 to 19.

and that I last saw h. alive on 19.

Immediate cause of death:

Traumatic skull

DURATION

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results: No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide:

Calvert Date of 4/16/45

Where did injury occur: Wellborn Calvert (City or town) (County) (State)

Injured at home, farm, industry, public place (where): Highway

Means of injury: Auto accident Injured at work? Yes

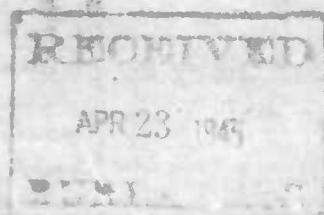
23. SIGNATURE:

H. A. Ward

Last and given names

Address: 517 Eleventh St. S.E. Date signed: 4/16/45

M. D. or other



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 20

CERTIFICATE OF DEATH

03780

Reg. Dist. No. 52

1. PLACE OF DEATH
County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?
Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborns indicate residence of mother)

State..... County.....
City or town.....
(If outside city or town limits, write RURAL and give nearest town)

Street No.....
(If rural, give LOCATION)

3. (a) FULL NAME
Clifton Ward

4. Sex..... 5. Color or race..... 6.(a) Single, married, widowed, or divorced
M W M

6.(b) Name of husband or wife.....
May Agnes Ward

7. Birth date of deceased (mo., day, yr.)
Feb 3 1872

6.(c) If alive, give age 70 years

8. AGE: Years Months Days If less than one day
73 2 4 hrs. min.

9. Birthplace.....
Maryland
(Town, county, and state)

10. Usual occupation.....
Merchant

11. Industry or business.....
Hardware Ward

FATHER
12. Name.....
John Ward

MOTHER
13. Birthplace.....
Alb

14. Maiden name.....
May Hallenip

15. Birthplace.....
Alb

16. Informant.....
Mr Clifton Ward

Address.....
N. Deak

Burial
17. (Burial, cremation, or removal. Which?) Date thereof.....
(month) (day) (year)
Burial April 9 1945

Cemetery or crematory.....
Mt Harmony

Location.....
Dwings Md.

18. Funeral director.....
Wm H. Hutchins

Address.....
Dwings Md.

19. Date rec'd by registrar.....
April 8 1945

Registrar.....
Wm H. Hanesky

Date signed.....
4/7/45

3. (b) Social Security Number

MEDICAL CERTIFICATION

10. DATE OF DEATH.....
4 7 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death.....
*Cerebral Hemorrhage*DURATION
1 hr

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

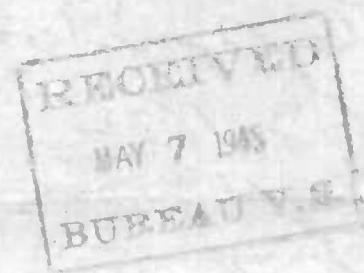
Means of Injury.....

Injured at work?

23. SIGNATURE.....

M. D. or other

Address.....
*H. Ward*Date signed.....
4/7/45



PLEASE WRITE PLAINLY, WITH NONFADING INK. Supply every item of information carefully. The correctness
is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 830

63781

CERTIFICATE OF DEATH

Reg. Dist. No. 50

1. PLACE OF DEATH:

County CalvertCity or town Solomons

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 1/2 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

Thomas William Woolford

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Male White Widowed

6. (b) Name of husband or wife

Bertie Horsemaw Woolford

7. Birth date of deceased (mo., day, yr.)

March 29 - 1872

6. (c) If alive, give age years

8. AGE:

Years	Months	Days	If less than one day
<u>78</u>	<u>0</u>	<u>27</u>	<u>hrs.</u> <u>min.</u>

9. Birthplace

Madison, Maryland

(Town, county, and state)

10. Usual occupation

Captain

11. Industry or business

Mercantile Marine

FATHER

12. Name Jethro Woolford

MOTHER

13. Birthplace Maryland

Maiden name

14. Maiden name Mary M. Moffett

Birthplace

15. Birthplace Maryland

16. Informant

Harrison Woolford

Address

Sussex, Maryland

Burial

17. Burial (Burial, cremation, or removal. Which?) April 29 - 45

Date thereof (month) (day) (year)

Cemetery or crematory

Cedar Bluff

Location

Annapolis, Maryland

Funeral director

Benjamin Hobbs

Address

Annapolis, Maryland

Date rec'd by registrar

April 26 45D. E. S. Coster

19. Date signed

(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Anne ArundelCity or town Annapolis (If outside city or town limits, write RURAL and give nearest town)Street No. 17 Jefferson St (If rural, give LOCATION)

2.(a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH April 26 - 1945 at 7:30 AM21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 9 - 1945 to April 26 1945 and that I last saw him alive on April 26 - 45 1945

Immediate cause of death

arterial hypertension

DURATION

4 hrs

Due to

arteriosclerosis4 yrs

Due to

Hemiplegia1 1/2 yrs

(Include pregnancy within 3 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

D. E. S. Coster

M. D. or other

Address Solomons, Md Date signed 4/26/45

